The encouraging response to *ImpAct* has created a problem. How can we find ways to cover all the good stories that come our way? With the best will in the world we won't be able to cover them all in the paper version. Our solution is the make greater use of the Internet. *ImpAct* is already available on-line at the *Bandolier* web-site in html and PDF formats.

From May 2000 there will be an extended site called "Managing to make a difference". It will have every story from *ImpAct* and about 100 stories from *Bandolier* which have management implications. In future we will scan for useful literature sources and add them. This is tough, though, because it is not always evident what type of information to look for, or what type of information is wanted.

So we would like *ImpAct* readers to become "stringers" for us. If you read a journal and see something (a review, or a randomised trial, or information about better use of resources) that makes **you** think "Wow, that's worth doing here!", then we'd like to hear about it. Be specific. Give the reference (and send a copy if you have one), and tell us why it is important for you. Over time this will then become a key resource for the "how to do it bit" that gets so little attention.

In addition to this we will be adding stories from the NHS for which we have no room in *ImpAct*. Two examples in May include:

A primary care focus for mental health

The Brookside practice in Reading has explored the value of a practice-based mental health practitioner. The post has been a real success – improving care for patients and developing a new approach to the management of mental health within the practice population. The Wokingham Primary Care Group is adopting the idea as it explores how to provide mental health services for its population.

Community assessment and rehabilitation teams in Cornwall.

Cornwall Healthcare NHS Trust has explored how to undertake multidisciplinary assessments of the health and social care needs of patients close to the threshold of institutional care. They have found ways to secure benefits for patients and tackled some important questions about links between teams and mainstream services.

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Finding ways to use local skills to improve the management of primary care in Hackney, East London

Why was the initiative launched?

In 1998, GPs in Hackney recognised their need for support on organisational issues like health and safety regulations and the development of staff appraisal systems. Later that year it became clear that a potential under-spend in the budget for the London Implementation Zone (LIZ) would offer opportunities to fund local development work.

Within days of the opportunity being known a project was proposed by the City and East London MAAG and the Practice Staff Training Unit at the Department of General Practice at Queen Mary and Westfield College (QMW). The project would offer organisational development support to practices. Existing staff would be involved. Practice managers and practice nurses who had experience of problem solving in their own practices and who also had skills to facilitate change in other practices. Short-term funding of £20,000 was allocated to the project in September 1998: the initial aim was to complete the work by March 1999.

What was done?

Caroline Lee, MAAG Co-chair and Gillian Borrie from QMW managed the project. Their first task was to recruit a team of facilitators who had both the necessary skills and who could also devote time to the project. They recruited five practice managers and one practice nurse. Several of these people had experience of working with the King's Fund Organisational Audit Programme in primary care. The team then drew up a list of development areas where they had expertise. The aim was to build on known prob-

*The views expressed in **ImpAct** are those of the authors, and are not necessarily those of the NHSE*

Figure 1: Practice Development Topics

Some examples:

- *Health and Safety regulation*
- *Appointment systems*
- *Team working*
- *Repeat prescribing*
- *Staff budgets*
- *Disease registers*
- *Complaints*
- *Job descriptions*
- *Telephone skills*

lem areas, but the project coordinators were conscious that practices 'would not know what they did not know'. The final list included 35 discrete topics, some of which are described in the Box.

At the end of October 1998, the project coordinators invited practices to participate and identify those topics on which they would like support. The letter was sent to general practitioners and practice managers and the project was publicised though local networks. The invitation indicated that the resources within the project were limited: practices were offered around one session (three hours) a week of facilitators time up to a maximum of 18 weeks.

Designed support

Eight practices responded to the initial invitation, seeking support on a range of issues. The requests from practices were followed up with an initial assessment visit from one of the team of facilitators whose expertise seemed to match the practice's needs. The visit was designed to diagnose the problems, assess the number of visits required to tackle it and devise a preliminary action plan. A programme of regular visits to the practices was then negotiated between the facilitator and the practice. The subsequent 'working' visits involved the facilitator and members of the practice team, including the practice managers, GPs, practice nurses and receptionists.

Regular monthly meetings between the facilitators and the project coordinators allowed the team to manage the demands on their time, set the framework for agreements with the individual practices and discuss any difficulties which had been encountered. It made it easy for another facilitator with more appropriate experience to step in when needed. The team took care to ensure that practices were aware that the team would respect confidentiality.

Did it work?

A second group of five practices was enrolled in the project in early 1999 so that 13 practices have now been involved. The thirteen included single-handed practices with a variety of issues to address and larger practices that required help with one issue. Some practices received just a few vis-

its whereas others have had regular input over a longer period of time. So far, the team has been able to meet the demand for its services, with no practice turned away.

Evaluation has been taken seriously and progress monitored closely. Each practice visit is documented and at the end of the facilitator's involvement a summary of the work undertaken is compiled. In addition, the project coordinators contact the practices to discuss how useful they have found the support offered.

Developmental phases

As the work has progressed, the project coordinators have recognised several phases in offering organisational development support to practices. The practices need to acknowledge that they need help. They need to be willing to discuss their problem and the options for improvement and they need to be ready to listen to new ideas. Finally they need to be willing adopt new ideas and devote the necessary resources to the task. Given the day-to-day pressures on practices, those offering developmental support need to be patient and allow the practices to go through these essential steps.

The funds available covered the sessional costs of the facilitators. Careful budget management has allowed the

Benefits to practices

Example 1: The practice recognised that several aspects of their organisation needed improving, including appointment systems, staff appraisal and questions about health and safety issues. The project has provided advice and information and is now working with the practice to adopt a range new systems and procedures.

Example 2: The practice was single-handed and finding it increasingly difficult to tackle administrative and financial tasks. The project was able to help the practice get over the immediate difficulty and with the appointment of part time bookkeeper.

Example 3: The practice was facing a move to new premises yet no one in the practice team had any relevant experience of how to manage the move. The project was able to draw on the experience of two practice mangers to plan and manage all the work involved from the physical process of moving to the installation of new IT equipment. The move went smoothly and the team were very pleased with the support offered.

project to be extended up to spring 2000. The success of the project has persuaded the Hackney Primary Care Group to adopt the project as a key element of its development and fund its continuation. The lessons from the work are also continuing to influence the training for practice managers run at QMW.

Tips for Success

✔ Remember that people need to accept that they need help before they will be able to use it!

✔ Be trustworthy and respect the confidentiality of practices and their patients.

✔ Work on early successes and make them known locally.

✔ Don't raise unrealistic expectations. Start slowly and test what you can do properly before being more ambitious.

✔ Value facilitation skills because not everyone that can work across professional boundaries.

✔ Be ready to respond to last minute opportunities to set up short-term development work.

✔ Know who has what skills and experiences.

Contacts

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The following material is available:

• Topic checklist - what the project offers.
• Anonymised summary of areas tackled in practices
• Assessment and reporting proforma.
• Interim project report

ImpAct bottom line

⇒ **Find ways to value and make the most of the skills and experiences of staff locally before you bring in 'outsiders.'**

CREATING A 24-HOUR MENTAL HEALTH SERVICE

Developing a new home treatment service in Stamford, Lincolnshire

Why was the initiative launched?

Rauceby Hospital was a large mental hospital in Sleaford, Lincolnshire, and closure was planned for the end of 1997. Questions about how mental health services would be provided for the rural populations of Stamford, Bourne and Market Deeping arose during planning for its closure. Geography was a real problem because Rauceby was about 30 miles away. Re-provision of acute mental health inpatient services could have been centred at Grantham, but that also was about 30 miles away. At the time another option explored by the Health Authority was to commission services from Peterborough, closer but over the county border in Cambridgeshire.

There were strong views, especially from GPs, that there must be ways to develop a local service that would meet the needs of the community. These views led to the agreement to create a home treatment service to complement the existing Community Mental Health Team based in Stamford. The challenge was to have the new service, the Stamford Resource Centre, in place by beginning of 1998.

How was the work handled?

A project team, led by Eddy Seymour, the general manager of mental health services, was appointed in 1995 to plan the new service. The lack of local experience in managing a community-based service encouraged the team to look at developments elsewhere. They visited other services and invited staff from services elsewhere to visit and pass on their experiences. All those involved were encouraged to see the work as an opportunity for their personal development. Each member was involved in two or three specific aspects of the work.

Gradually, during 1996, a model for a new nurse-led service was talking shape: the key elements would be:

♦ 24 hour on-call crisis assessment and management
♦ Care and treatment at home
♦ A day hospital
♦ An eight bed inpatient facility

24 hour telephone helpline.

The overall design was only the start. Policies and proce-

Table: Stamford Resource Centre: referrals and use telephone helpline

	1998			1999			
	Jun	Sep	Dec	March	June	Sep	Dec
Calls to helpline	171	113	104	145	144	260	427
Crisis referrals to HTS/CMHT	22	25	37	43	28	33	25

dure to enable it to operate were required. The main challenge was to develop a model for the 24-hour crisis service that would work in a rural community and in which staff felt safe and supported. Groups of staff nurses did most of the work. For example, they established ways to assess risk and create treatment protocols. Completing the premises before the new service went live was helpful. The team had time to settle in before the service started. This space meant that the Home Treatment Service and the Community Mental Health Team were able to get to know one another.

Training and Staffing

It became evident that an extensive training programme would be required to equip a new group of staff to tackle the challenging roles. A Centre Manager was appointed in 1996 to bring the preparations together. Success required acceptance of a new model of care unfamiliar to many patients, carers and staff. The manager was able to recruit a team keen to work in the new and innovative service. This contrasted with other areas where staff were redeployed from the old institution at Rauceby to alternative inpatient facilities. Although none of the team had experience in home treatment they had a wealth of mental health experience.

Two other issues required attention. Out-of-hours junior psychiatric cover would be provided from Grantham Hospital which could be a problem. Creating working relationships between the Home Treatment Service (a 24-hour, 7 day service) and the Community Mental Health Team (a 9 to 5, Monday to Friday service) also proved challenging. Ways are being found to improve links by making sure that communications between to the two teams are effective.

Is the new service working?

As the model for the new service was taking shape research evidence demonstrated that *'where a home treatment model of care has been introduced it has - on average - reduced hospital admissions by two thirds'. (*Dean and Gadd, BMJ 1990).

Experience from Stamford reaffirmed those estimates. Admission to hospital fell by 60% in the first year. The Centre opened as planned in February 1998 and is exceeding expectations. It has proved popular with staff and patients.

".. nurse assessments have proven to be a great asset in the provision of continuity of care. It has also enhanced my own professional development". (E grade nurse in the HTS*)*

"The staff at the centre offer professional, caring and friendly support for the many people who use the centre." (service user*)*

The overall success of the new service has been acknowledged by the granting of Beacon Status in 1999.

The Home Treatment Crisis Service has a target response time of four hours but so far all (127 patients in the first year) have been seen within two hours. Teams of two nurses working with strict assessment protocols undertake the crisis visits. Only 32% of these referrals in 1998/99 led to inpatient admission. The remainder of patients were cared for by the Home Treatment Service (32%), transferred to the Community Mental Health Team (11%), referred for day care (13%) or discharged. The level of activity overall has matched expectations and remained broadly stable over the two years since the Centre opened (Table1).

The 24-hour telephone helpline is proving popular with patients, carers and health professionals. Psychiatric "first aid" is provided, but an immediate response from the crisis team can be triggered if required. Anecdotal evidence from general practitioners suggests that the service is reducing demands on them. There has been a steady rise in its use (Table 1), although action to improve the accuracy of recording may mask the true rate of change.

The eight-bed inpatient unit is matching expectations with a significant reduction in inappropriate admissions. The majority of admissions fall within the Mental Health Act. Home treatment is designed as part of the care plan enabling earlier discharge. All inpatients attend the day hospital. The unit can provide accommodation for a mother suffering post natal mental health problems and her baby.

The day hospital operates for 12 hours each day and for seven days a week. It is proving popular with patients. In an absence of reliable local public transport, the Centre provides transport driven by centre staff known to patients.

The Centre has a user group that has already suggested ways of improving the service. It has raised funds for the purchase of equipment to benefit users of the service. Two staff nurses have set up a carer's group which is offering support, advice and information. The group sets its own agenda and invites different speakers to present topics of interest.

Tips for success

✔ Involve clinical staff in designing new premises, but make sure they have time to make a real contribution. It takes time and is difficult to build into a busy clinical workload.

✔ Learn lessons from elsewhere when developing new training courses, for example for crisis work.

✔ Learn to live with the problems caused by administrative and geographical boundaries because they won't go away.

✔ Make sure that new premises work before they go op-

erational.

✔ Ensure that suitable back up is available for staff working alone in challenging situations.

✔ Regular team building sessions a must! But it is difficult when staff are required to cover a 24-hour service. Don't expect to get them all in one room at one time!

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The following material is available:

• Crisis assessment form
• Admission/referral risk assessment checklist
• Home Treatment Service explanatory booklet
• Centre Leaflet

ImpAct bottom line

⇒ **Take time out to learn about developments elsewhere when developing new services: don't re-invent the wheel!**

MAKING SPACE FOR CLINICAL GOVERNANCE

Creating clinical governance systems for the Regional Forensic Psychiatric Service at Langdon Hospital in Devon

What prompted the initiative?

When the Government introduced the concept of clinical governance it echoed feelings within the Regional Forensic Psychiatry Service at Langdon Hospital that there was a need to improve systems to support the development of good clinical practice. Clinical audit had been rolling forward with mixed success, but there was no coordination with other areas such as risk management and evidence-based practice. There was a strong desire to take the opportunity to create a better system that would get away from the prevailing ad-hoc, last minute approach. The time seemed right to create a multidisciplinary pro-active approach delivered in a way that enabled all staff to participate.

What has been done?

In common with many other hospitals the starting point at Langdon was to review the senior committee structure. These discussions were guided by four basic principles:

1   *leadership* would be essential at different levels;
2   it should be *multidisciplinary* in style;
3   all elements would be *actively coordinated*;
4   work involved would be *shared across the service*.

The latter point was particularly important given scarcity of resources. There was a new challenge but no new money.

Predictably two senior committees are the centrepiece of the new arrangements. One is a Trust Clinical Governance Committee chaired by the Medical Director. The other is a Forensic Mental Health Clinical Governance Committee chaired by a Specialist Registrar rotating on a yearly basis. Other developments include individual service committees for each sub speciality and annual professional standards reviews between the Medical Director and individual consultants. A training group is charged with supporting continued professional development across all disciplines. The key innovations within the new arrangements are however *five multidisciplinary steering groups* at local service level that report to the main clinical governance committee and the introduction of *clinical governance afternoons.*

The five multidisciplinary steering groups are charged with investigating practice and developments which might be applicable at Langdon Hospital and proposing how those should be taken forward. Each group is led from different disciplines

♦ Evidence based practice by a consultant psychiatrist.
♦ Risk management by a forensic psychologist.
♦ Policy and Procedure by a nurse manager
♦ Clinical Audit by the senior occupational therapist
♦ User Issues and Complaints is led by a general manager

The groups take a proactive approach to develop and roll forward a programme of work. As separate tasks are completed the work is presented at the clinical governance afternoons.

Clinical Governance afternoons

This arrangement was seen as a means of tying together the separate elements of the new system and ensuring that all staff are involved. The aim was to set aside time for presentation and discussions on topics that were important to the development of practice. The idea was to build on the

Table: Structure of clinical governance afternoons

Time	Training
13.00 - 14.00	Evidence-based practice presentation
14.00 - 14.45	Policy and procedure - alternating with clinical audit
15.00 - 15.55	Risk management - alternating with User and Complaint issues

model of previous clinical audit sessions but design them in a way that would give staff more of an incentive to attend. To support this approach there is an obligation on all professional heads to ensure that members of their discipline are able to attend. For example, the rosters for nursing staff have been amended to ensure that they are able to attend while cover on the wards is maintained.

The five multidisciplinary steering groups are involved in creating the programme for the sessions. The programme is circulated well in advance and professional accreditation obtained. There are ten sessions each year avoiding the holiday months of August and December. Lunch and a lucky door prize is provided courtesy of the local representative of a pharmaceutical company. The Table shows the basic framework for these meetings.

Is it working?

There are encouraging signs that the new coordinated approach is working and there is some anecdotal evidence that practice has changed. The discussions have been very productive. Guidelines have been agreed for the treatment of resistant schizophrenia and high dose neuroleptic medication. Integrated care-pathways are being developed for alcohol related and sexual offender treatment issues. In addition a policy and procedure on racism is being developed following a presentation in a clinical governance afternoon. A new risk prediction instrument is also being piloted.

Since the Clinical Governance afternoons were launched in May 1999 they have all taken place as planned. Attendance is encouraging with about three times the level for the old clinical audit sessions (up from about 10-15 to about 30-35). Debate has been lively and staff from most disciplines have been involved. An attendance register is maintained, as well as a record of presentations and discussions. Staff say they enjoy the meetings. The programme is now an important element of the continuing professional development of staff.

But it is not all plain sailing. A number of difficulties have arisen as the new approach has evolved. The will remains however to make sure that the opportunity created by the implementation of clinical governance is not lost. The problems include funding for the new arrangements because effective coordination does not just happen. Similarly, maintaining the right balance between team development and the needs of individual disciplines is proving difficult. Discussions are also in hand to ensure that all disciplines are involved, particularly singleton professional groups like speech therapy.

Tips for success

✔ Don't try to set up a clinical governance system a bit at a time because you'll never get there! Create a complete system from the beginning.

✔ Engage all disciplines in leading working groups and don't limit the role to particular disciplines.

✔ Make sure each group has a pool of staff from different disciplines and different grades. Extended memberships helps build 'ownership and avoids gaps when staff leave.

✔ Plan well in advance and give people dates when they will present the results of their work.

✔ Put a commitment to clinical governance in all new job descriptions.

✔ Provide refreshments for clinical governance afternoons and allow plenty of time for informal chats over a cup of coffee.

✔ Remember that the coordination of clinical governance can be a good training opportunity for specialist registrars. If they do it for only a year at a time they should not burn out.

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The following material is available:

Clinical governance and mental health: a system for change. Adrian James - Clinician in Management 1999:8 : 92-100

ImpAct bottom line

⇒ **Make sure that people can get involved. Change rosters so that they can attend training sessions.**

TACKLING DUAL DIAGNOSIS: GETTING THE RIGHT BALANCE

Creating a specialist service for people with learning disability and epilepsy in Birmingham.

Why was the initiative launched?

In 1997 staff in the Birmingham Services for People with Learning Disabilities became increasingly concerned about the quality of care and treatment being provided to people with a dual diagnosis of learning disability and epilepsy. There was a strong feeling that management of epilepsy was being neglected. Two national publications had encouraged action. The Department of Health in "Signposts for Success in Commissioning Services for People with Learning Disabilities" argued for recognition of epilepsy care as a specialist need. Later the British Epilepsy Association (BEA) offered guidance on an ideal epilepsy service. A growing local consensus urged that something needed to be done to improve the care and treatment for this group of clients.

What was done?

Initial negotiations to create an Epilepsy Liaison Team were led by a local consultant psychiatrist and two community nurses with special interest in epilepsy. After lengthy discussions, two part time community nurses were each seconded for nine months to acquire the necessary skills, training and experience in managing epilepsy. External funding enabled the nurses to acquire the Diploma in Epilepsy Care (Distance Learning Pack, Leeds University). The team also included a specialist registrar and a representative from the Trust's Clinical Governance Team.

The team's objective was to provide a specialist epilepsy service and improve the quality of life of people with learning disabilities and epilepsy. Improved management, monitoring, seizure control and education would be elements of their work. To develop the new service, the team first set out to answer three questions.

What were the immediate needs?

A survey of *community nurses* reinforced concerns already being voiced by staff in the Trust. These were echoed in an informal survey of consultants' practices. There was:

♦ Significant variation in practice.
♦ No agreed protocol to guide the assessment of clients.
♦ Lack of clarity about the treatment and monitoring of epilepsy care.
♦ No protocol for referrals to specialist epilepsy services.

The results highlighted the need for training of nursing and non-nursing staff. A survey of clients and carers pointed at the unsatisfactory nature of information provided at the time of diagnosis or later, about prescribed medication, social and employment issues and support organisations. There was a tendency for information to be provided verbally. Few leaflets were available.

What is the available clinical evidence in managing learning disabled people with epilepsy?

The paucity of evidence related to this group of people had been long apparent. Most of the literature dealt with epilepsy management of learning disabled clients in hospital settings and the majority of clinical studies on efficacy of medical treatments had been carried out on the general population. These findings are, naively, extrapolated to the learning disabled population who are already neurologically impaired and hence more vulnerable to the adverse effects of medication.

The team was not able to identify an accessible source of information on learning disability and epilepsy. In view of this they decided to assemble a collection of relevant research papers and publications to support their work.

How to address the immediate needs?

The results of the survey informed the design of a training programme for community nurses and other clinical staff. Two levels of training are available. An initial course for non-nursing staff covers basic awareness of epilepsy. More advanced courses for nursing staff, in addition to the basics, include the management of Non-Epileptic Attack Disorder (NEAD), Sudden Unexplained Death in epilepsy and epilepsy syndromes. Pharmaceutical companies have funded this aspect of the work.

Following the success of the early stages, assessment protocols are now being tested and information packs for clients and carers being prepared. There are plans to build on the current courses and offer more specialised training.

Is it working?

Since the new service was launched, the number of clients seen has risen by over 20% (from 82 to 101), a sound endorsement of the need for a specialist service. Specific improvements can now be seen in three clinical areas as well as other aspects of the team's work.

Monitoring has improved by the use of seizure diaries: it is more objective and precise. Carers and clients are better informed about individual seizure types including NEAD resulting in improved reporting.

There are several indicators of improved **quality of life** for clients and carers - see box.

♦ Fewer aggressive outbursts are reported. Carers can manage situations more easily
♦ Clients have easier access to community facilities with improved opportunities in life experiences and improved confidence of carers in taking clients out.
♦ Improved seizure control with reduction in seizure frequency (10%) and seizure severity (6%)

Progress is being made in **rationalising medication**. Reduction of medication is always discussed with carers if patient has been seizure free for over two years. The majority have been reluctant to have medication reduced and some changes have not been successful. Similarly some patients on medication such as phenytoin and phenobarbitone are being substituted with newer anticonvulsants in order to reduce side effects such as sedation and gingivitis. But changes have not been made where seizure control has been good and side effects minimal.

The **Epilepsy Resource Centre and Clinical Database** is taking shape. It is providing easy access to publications, books and videos, research papers, relevant guidelines and other sources of information. Currently over 400 relevant papers have been identified, indexed and summarised. Search tools are being developed to enable staff across the Trust to search for information on epilepsy through an intranet. If progress is maintained both facilities will be made available to other Learning Disability Services.

The **training courses** for community nurses have been well received. So far over 50 nurses from the Trust have received training from the Epilepsy Team. Pre- and post-training questionnaires show significant improvement in the scores of those participating.

The work has prompted the creation of a **special interest peer group** for nurses: the Focus in Epilepsy and Learning Disabilities group (FIELD). This was set up in 1999 by Julie Shumary to provide support, enable the sharing of information and promote good practice. The group has met five times and more meetings are planned. Membership includes nurses with a special interest in epilepsy from organisations across Central England. Topics being addressed include protocols for emergency treatment in epilepsy and consent to treatment. FIELD aims to offer a collaborative approach to epilepsy care and is planning a conference this year as a forum for sharing best practice.

Tips for success

✔ Don't underestimate the lack of understanding about the care and treatment of people with a dual diagnosis of learning disability and epilepsy.
✔ Devote time and effort to forging new links with colleagues.
✔ Explore different ways to develop new teams, for example, through secondments.
✔ Diagnosis of epilepsy in this group of people is complex: a full review of new clients is essential.
✔ Work constructively with pharmaceutical companies in ways that avoid complaints of bias, like the supply of educational material, advice on auditing and using computer programmes related to epilepsy management.
✔ Develop ways sensitive to the needs of local groups when addressing language barriers. Written material may not be the answer.

To find out more - contact a member of the team

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ImpAct bottom line

⇒   **Be patient and persistent - creating effective services for small groups takes time. There are no quick answers**